CHAPTER I

PSYCHOLOGICAL WELL-BEING AND NURSING
PERSONNEL IN HOSPITALS – AN OVERVIEW

INTRODUCTION

According to the World Health Organisation, health is “a state of complete physical, mental
and social well-being and not merely the absence of disease or infirmity” and mental health
is “a state of well-being in which the individual realizes his or her own abilities, can cope
with the normal stresses of life, can work productively and fruitfully, and is able to make a
contribution to his or her community.”

Concept of Psychological Well-Being

According to Diener and Emmons (1984),\textsuperscript{1} in the field of psychology, much attention had
been given to human unhappiness and suffering rather than to the causes and consequences
of positive functioning. According to Huppert (2009),\textsuperscript{2} “Psychological well-being is about
lives going well. It is the combination of feeling good and functioning effectively.” People
with high PWB report feeling happy, capable, well-supported, satisfied with life, and so on.
According to Deci & Ryan (2008),\textsuperscript{3} psychological well-being is defined as combination of
positive affective states such as happiness (the hedonic perspective) and functioning with
optimal effectiveness in individual and social life (the eudaimonic perspective). The
hedonic approach focuses on happiness and defines well-being in terms of pleasure
attainment and pain avoidance. According to Eudaimonic view, well-being consists of
more than just happiness. It lies instead in the actualization of human potential. The
research on psychological well-being has progressed rapidly since the emergence of the
field over five decades ago. The psychologists and other social scientists have made intense
efforts to understand the factors influencing psychological well-being.

Psychological well-being refers to how people evaluate their lives. According to Diener
and Tov (2007),\textsuperscript{4} these evaluations may be in the form of cognitions or in the form of
affect. The cognitive part is an information based appraisal of one’s life that is when a
person gives conscious evaluative judgments about one’s satisfaction with life as a whole. The affective part is a hedonic evaluation guided by emotions and feelings such as frequency with which people experience pleasant/unpleasant moods in reaction to their lives. The assumption behind this is that most people evaluate their life as either good or bad, so they are normally able to offer judgments. Further, people invariably experience moods and emotions, which have a positive effect or a negative effect. Thus, people have a level of subjective well-being even if they do not often consciously think about it, and the psychological system offers virtually a constant evaluation of what is happening to the person.

Psychological well-being is not about temporary well-being but sustained well-being. Sustainable well-being does not require individuals to feel good all the time. The experience of painful emotions like disappointment, failure and grief is a normal part of life, and being able to manage these negative or painful emotions is essential for long-term well-being. Psychological well-being is, however, compromised when negative emotions are extreme or long lasting and interfere with a person's ability to function in his or her daily life.

The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence, and affection. The concept of functioning effectively involves the development of one's potential, having some control over one's life, having a sense of purpose like working towards a specific goal, and experiencing positive relationships with people.

Recent years have witnessed a tremendous shift in the research literature from an emphasis on disorder and dysfunction to a focus on well-being and positive mental health. This paradigm shift has been especially prominent in psychological research conducted by Argyle, Diener, Kahneman, Seligman, Ryff and Singer. It has also captured the attention of epidemiologists, social scientists, economists, and policy makers.

This recent research on mental well-being has highlighted the following factors:
Well-being is more than the absence of ill-being. It needs to be studied in its own right. Many of the drivers of well-being are not the same as the drivers of ill-being.

There is a need to distinguish between the approaches to improving psychological well-being: (a) treating disorder when it is present (b) preventing disorder from occurring and (c) enhancing well-being (i.e. increasing flourishing).

There is a strong possibility that, by increasing well-being in the population, we might be able to reduce common mental and behavioral problems than by focusing exclusively on the treatment and prevention of disorder.

**Implications of Psychological Well-being**

Many studies on well-being found that people who are high on psychological well-being enjoy good physical health, live longer compared to people who report less on psychological well-being and report less in suffering from diseases especially stress related diseases. In a famous longitudinal study called ‘The Nun Study’, Danner, Snowdon, and Friesen (2001)\(^5\) studied the autobiographies written by Nuns in their early twenties. The autobiographies were categorized according to the number of positive statements they contained. The researchers found that nuns in the lower half of the distribution of positive statements died on average nine years sooner than those in the top category of positive statements. These results are particularly important because, from their early twenties, the lives of the nuns were very nearly similar. Hence, the difference in survival was not related to their lifestyle or circumstances in the intervening period, but to their positive emotions six decades earlier.

Some more longitudinal studies have emphasized the importance of positive emotions in health and survival (2003)\(^6\). An important physiological mediator underlying the relationship between positive emotions, health, and survival is likely to be the functioning of the immune system. This has been proved in experimental studies such as those by Cohen and his colleagues\(^7\). In one study by these researchers, several hundred healthy volunteers were administered nasal drops containing a common cold virus, and monitored in quarantine. The investigators found that the more positive the participant’s emotional style, the lower his/her risk of developing a cold. However, negative emotional style was not associated with developing a cold. Another study by the same researchers found that
sociability was linearly related to decreased probability of developing a cold. A study by Marsland, Cohen, Rabin, and Manuck (2006) examined the relationship between emotional style and antibody response to the Hepatitis B vaccine. Participants with high scores on trait positive affect produced more antibodies to the vaccine. There was no relationship between antibody response and either trait negative affect or depression. The above studies assessed the emotional style of the participants but did not use experimentation to alter emotions and verify. Therefore, it is difficult to be sure whether the individuals’ positive characteristics were causally related to the outcome or whether there was a common cause of both the characteristics and the outcome. The direction of causality is much clearer in the classic study by Davidson et al. (2003). Using an intervention which increases positive mental states (mindfulness meditation), they reported that the meditation group produced a higher antibody response than the control group to an influenza vaccine. Positive mood has also been shown to positively influence the cardiovascular response to stress.

Fredrickson, Mancuso, Branigan, and Tugade (2000) exposed volunteers to a stressful task followed by a mood induction procedure. Subjects in a positive mood state showed much more rapid cardiovascular recovery from stress than those in a negative or neutral mood state. Prolonged reactivity to stress is harmful to immune function and to other physiological processes, while a rapid recovery from stress is beneficial for health. A study by Lai et al. (2005) directly investigated the effect of optimism on the secretion of the stress hormone, cortisol. Positive affect and optimism had somewhat different effects on the diurnal pattern of salivary cortisol secretion, but both were associated with a healthy pattern, compared to negative affect and pessimism. In a recent review of well-designed prospective and experimental studies, Pressman and Cohen (2006) concluded that there is strong evidence for a beneficial effect of positive emotions on physical health and survival, and that this effect may be independent of the level of negative emotion. Indeed, some of the studies cited above suggest that, in the general population, positive affect (or the lack of it) may exert a more powerful effect on health and physiology than the presence of negative affect. This startling conclusion may have hitherto been obscured by the focus on pathology which has dominated biomedical science. Pathology-oriented research used measures which fail to differentiate between the presence of negative experiences and the absence of positive experiences. There are a number of pathways through which positive emotions can exert their positive impact on health. Evidence cited above supports the view
that positive mental states can have direct effects on physiological, hormonal, and immune function which, in turn, influence health outcomes. Behavioral and social factors may also mediate the link between positive emotions and health. According to David, Lee and Auke\textsuperscript{13}, happier people tend to have healthier lifestyles, more friends and positive interpersonal experiences. Thus, the health benefits of positive emotional states may not be directly attributable to positive feelings, but to health practices or social factors that are known to have beneficial effects on health and life expectancy. The social factor that has been most studied in relation to health is receiving social support. According to House, Landis, & Umberson (1988)\textsuperscript{14} social support moderates and protects individuals against physical and mental health problems. More recent evidence has established the powerful role of providing support to others. In a prospective study of hundreds of elderly couples, Brown and her colleagues Nesse, Vinokur, & Smith, 2003\textsuperscript{15} found that mortality was greatly reduced in individuals who reported providing instrumental or emotional support, compared to those who did not, and this effect remained after adjustment for a host of potential health, behavioral, and socio-demographic confounders. The investigators also found that receiving support had no significant effect on mortality. There is evidence from surveys that giving support in the form of volunteering may be associated with higher levels of psychological well-being.

For instance, a study by Greenfield and Marks (2004)\textsuperscript{16} found that in older people, volunteering was associated with more positive affect and more meaning in life. Policies which encourage people to give support to others in the form of volunteering or mentoring are likely to have health benefits as well as personal and societal benefits.

**Determinants of Psychological Well-Being**

The factors that determine psychological well-being include workplace factors and non-work factors. The demanding work at workplace, lack of control over work and, conflicts with colleagues, frequent travel, poor family relationships, misunderstandings in dual career families, lack of Job security, poor working conditions have a negative impact on psychological well-being. Workplace autonomy, support from colleagues, good relations with colleagues and superiors, good relations with family members, reasonable job
security, recognition of good work with rewards and awards have a positive impact on psychological well-being (Refer Figure 1.1).

**Figure 1.1: Concept of Psychological well-being**

![Diagram](source)


Danilo Garcia (2006)\(^{17}\) conducted a study to examine the relationship between hedonic and eudaimonic well-being in adolescents with respect to interpretation and memory for stimuli outside and inside autobiographical memory and affective personalities. A total of 70 male and 65 female high-school students with an average age of 17 years and S.D. of 0.88 participated in the experiment. Well-being was measured as Subjective Well-Being (SWB) and Psychological Well-Being (PWB). Interpretation and memory was measured with recognition of words in a short story and recall of life events. Affective personalities were developed through PANAS. The results showed self-acceptance and environmental mastery as the eudaimonic predictors of SWB. Adolescents with high levels of well-being remembered more positive life events and used mixed strategies to discriminate memory for words. Adolescents with high levels of well-being showed a positive priming effect and those with low levels a negative priming effect. Finally, Self-actualizing and self-
destructive individuals emerged as the happy and unhappy personalities for both perspectives.

Robert J. Vallerand (2012)\textsuperscript{18} studied the role of passion in Psychological well-being from a different perspective. Passion is defined as a strong inclination towards a self-defining activity that people find important, and in which they invest time and energy on a regular basis. His research study revealed that harmonious passion contributes to sustained psychological well-being while preventing the experience of negative affect, psychological ill-being. However, obsessive passion doesn’t produce such positive effects and may even facilitate negative affect, conflict with other life activities, and psychological ill-being.

According to K W Brown (2003)\textsuperscript{19} and Ryan R M, mindfulness is an attribute of consciousness long believed to promote well-being. Mindfulness can be considered as enhanced attention to and awareness of current experience or present reality. Consciousness encompasses both awareness and attention. Awareness is the background “radar” of consciousness, continually monitoring the inner and outer environment. One may be aware of stimuli without them being at the center of attention. Westen\textsuperscript{20} defined attention as a process of focusing conscious awareness, providing heightened sensitivity to a limited range of experience. In actuality, awareness and attention are intertwined, such that attention continually pulls “figures” out of the “ground” of awareness, holding them focally for varying lengths of time. The study provides a theoretical and empirical examination of the role of mindfulness in psychological well-being. The development and psychometric properties of the dispositional Mindful Attention Awareness Scale (MAAS) are described. Correlational, quasi-experimental, and laboratory studies then show that the MAAS measures a unique quality of consciousness that is related to a variety of well-being constructs, that differentiates mindfulness practitioners from others, and that is associated with enhanced self-awareness. An experience-sampling study shows that both dispositional and state mindfulness predict self-regulated behavior and positive emotional states. Finally, a clinical intervention study with cancer patients demonstrates that increases in mindfulness over time relate to declines in mood disturbance and stress.
Many researchers have found that other factors like leadership style, professional commitment, workplace engagement, assertiveness, demographics, resilience, etc determine psychological well-being of individuals. The following is the description of concepts of leadership style, professional commitment, work place engagement and assertiveness that are considered in the present study:

**Figure 1.2: Leadership Styles**


**Concept of Leadership Style**

Leadership is a process of motivating and organizing a group of people to achieve a common goal. Different leaders adopt different styles (Refer Figure 1.2) in leading their people. Some leadership styles are more effective than others in different situations depending on specific challenges being faced and particular needs of the followers. An autocratic leaders dictate their terms and conditions to followers. They never seek any input from subordinates in setting goals or making critical decisions. They are task oriented and ignore people’s concerns, feelings and fears. Autocratic leader discourages creativity and insist that all tasks to be performed by followers as specified by him without any deviation. This kind of leadership style is suitable in situations where there is time urgency in completion of task, when task completion demands higher level skills and followers have
low skills and when an organization is in crisis and small errors by followers can prove fatal to survival of the firm. However, long-term use of this style can create distrust, dissatisfaction and resentment among followers. Democratic leaders involve people in setting goals, making important decisions and their implementation. They seek creative ideas from subordinates and reward the employees who give best solutions. Under this leadership, people develop high morale, sense of personal and professional growth and job satisfaction. This leadership is highly effective when subordinates are highly skilled and motivated and when an organization is implementing operational changes to face competition.

In Transactional leadership style, the leader demands subordinates to follow his instructions to achieve a set goal and in turn promises to offer some financial benefits. This approach is appropriate when short-term goals need to be achieved urgently. When subordinates rise to a level where the financial benefits fail to appeal, the transactional leader may see high turnover in his team. In Charismatic leadership style, leaders inspire, motivate and energize followers. Inspired team members strive hard to produce exceptional results and bring name and fame to the leader. This style is appropriate in situations when the leader cannot promise anything tangibly and with certainty of specific benefits. For example, in politics, no leader can promise with certainty before election results that team members will get ministerial positions. But charismatic leader often attributes success to himself and his own talent. The leader refuses to recognize the warnings given by well-wishers and is doomed to failure owing to over-confidence. In Transformational leadership style, leaders recognize the intrinsic needs of followers and focus on long-term goals rather than short-term goals of organization. They gain genuine trust of the followers. As subordinates trust their leaders, they make efforts to use their optimum capability and deliver high level performance. This style is appropriate in situations where organization needs to undergo drastic and permanent change. It is considered to be one of the best styles of leadership.

Kuoppala\textsuperscript{21} and colleagues conducted meta-analysis of studies on leadership style and suggested that effective leadership style enhances the well-being of employees which in
turn enhances employee performance and organizational profitability. A leader can be said to be effective when he can make his employees feel that they are working to a shared goal, they are given good feedback for high performance, they are given opportunity to learn new skills through training, their leader “leads by example”, their leader offers intellectual stimulation through challenging work and their leader encourages them to be creative.

**Figure 1.3: Commitment to Nursing Profession**

![Diagram showing the relationship between Commitment to Nursing Profession, Compassion for patients, Respect for human dignity, Upgrading Knowledge through ongoing Learning, Integrity in delivering job duties and responsibilities, and Trust in colleagues.]


Many studies by researchers like Arnold, have identified that the above perceptions were seen in employees working under transformational leaders. Transformational Leadership style is not only important to improve workplace health, but also for enhancing employee engagement and boosting organization’s productivity, and profitability. If leaders in organizations can improve their Transformational Leadership qualities (augmenting communication skills, self awareness and ability to recognize the needs of others) they can
then turn around the fortunes of even ailing businesses. The term “Transformational leadership” was first coined by James Downtown in 1973\textsuperscript{23}. The term was later popularized by political sociologist James MacGregor Burns in 1978\textsuperscript{24}.

According to Bass\textsuperscript{25}, transformational leaders broaden and elevate the interests of their employees. They generate awareness and obtain acceptance from employees, of the purpose and mission of the organization. They inspire their employees to sacrifice their self-interest for the good of the group. Transformational leaders can use different approaches to motivate employees. They can use charisma i.e., behaving in admirable ways and appealing to followers on an emotional level. They can use inspirational motivation i.e., articulating an ambitious vision that is appealing and inspiring to followers, challenging followers constantly, and providing sense of purpose for the task at hand. They can also use intellectual stimulation approach where the leader encourages followers to explore their inner talents to find unique solutions to problems. The transformational leader can also use individual consideration which involves listening to the follower's concerns and needs, offering them necessary mentoring and creating opportunities to fulfill their need for self-actualization.

**Concept of Professional Commitment**

Professionally committed people never compromise with quality of work. They strive to improve their knowledge base and skill set to continuously improve their quality and productivity at work. They initiate various tasks pro-actively and deliver the best quality work that they are capable of. They are willing to work in a team with others and determined to achieve a common goal. They uphold the values and principles of their profession. They are found by the employer to be reliable, dependable, responsible and accountable for the tasks they are assigned (Refer Figure 1.3). They work with honesty and transparency, and uphold the faith that the employer has kept in them. They treat the work place with respect and avoid any unprofessional behavior.

Vandenberg and Scarpello (1994)\textsuperscript{26} defined professional commitment as “a person’s belief in and acceptance of the values of his or her chosen occupation or line of work, and a
willingness to maintain membership in that occupation.” This widely accepted definition limited the construct to the affective dimension. People who have high professional commitment have strong belief in professional values. They accept goals set for them by the organization enthusiastically and make considerable efforts to fulfill the professional objectives and responsibilities. They work with passion and function with integrity.

Every 10 percent improvement in commitment can decrease an employee’s probability of departure by 9 percent. Every 10 percent improvement in commitment can increase an employee’s effort level by 6 percent. Every 6 percent improvement in effort can increase an employee’s performance by 2 percent. Companies with above average employee commitment had greater one-year revenue growth relative to their industry than those with below-average employee commitment.²⁷

**Figure 1.4: Employee Engagement**

![Engaged Employee Behavior Diagram]

Source: CBSR and Hewit Associates, “Engaging Employees through CSR” Webinar 2010

Meyer²⁸ et al. defined three dimensions of professional commitment – affective, continuance and normative. Affective professional commitment (APC) refers to an identification with, involvement in, and emotional attachment to profession²⁹. Professionals with a strong sense of affective commitment to their profession keep themselves abreast of latest developments in their profession by subscribing to trade journals, attending professional meetings, and participating in their professional associations. Continuance
professional commitment (CPC) refers to commitment based on the employee’s recognition that costs associated with leaving their profession are high. Employees with strong continuance commitment remain with their profession because they realize that they have much to lose by not doing so. For example, professionals with high levels of continuance commitment might be less inclined to involve themselves in professional activities other than those required to retain membership of their profession. Normative professional commitment (NPC) refers to commitment based on a sense of obligation to the profession. Employees with strong normative professional commitment remain members of their profession because they feel they ought to do so. Normative professional commitment may develop because of effective professional socialization or the sacrifices involved in becoming a member of a particular profession.

**Concept of Work Place engagement**

Schaufeli and his fellow researchers (2002) emphasized that employee engagement is a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption. Rather than a short and specific state, engagement refers to a more enduring and all-encompassing emotional and logical state that is not focused on any particular object, event, individual, or behavior. Vigor is characterized by high levels of energy and mental pliability while working, the willingness to devote time and effort in one’s work, and perseverance even in the face of difficulties. Dedication refers to being strongly involved in one's work and experiencing a sense of significance, passion, motivation, dignity, and challenge. Absorption is characterized by being fully determined and happily immersed in one’s work, whereby individual experiences pleasure in working and finds it difficult in separating oneself from work.

Engagement is the extent to which employees commit to work and collaborate with colleagues in their organization, how hard they work and how long they stay (Refer Figure 1.4) as a result of that commitment. Engagement is the employee’s positive emotional connection to his work. Engagement is affective, normative, and continuance commitment. Engaged employees are inspired to go above and beyond the call of duty to help his organization meet business goals. Maslach and Leiter (1997) stated that engagement is adequately measured by reversing Maslach Burnout inventory (MBI) scores. However,
others do not favour this opinion in view of the substantial evidence that positive and negative aspects of work-related well-being have their own pathways and contingencies. In line with the argument that positive and negative aspects of work-related well-being are not necessarily each other’s opposites. Schaufeli, Salonova, Gonzalez Roma and Bakker suggested that positive and negative work aspects should be measured independently.

David Ulrich\textsuperscript{31}, in his best-selling book Human Resource Champions stated that “Employee contribution becomes a critical business issue because in trying to produce more output with less employee input, companies have no choice but to try to engage not only the body, but also the mind and the soul of every employee.”

According to Hewitt\textsuperscript{32}, engaged employees consistently demonstrate three general behaviors – say, stay and strive. Say refers to employee willing to speak positively about the organization to coworkers, potential employees, and customers. Stay refers to the strong desire of employee to be a member of the organization despite opportunities to work elsewhere. Strive refers to the employee’s readiness to spend extra time, effort, and initiative to contribute to business success”

Many research studies seek to study the relationship between engagement levels of individual employees and their job performance and absenteeism rate. Similarly, there are many studies finding relationship average engagement levels of work teams and the performance of team and rate of absenteeism. Also the impact of average engagement levels of business units on their profit and productivity is also widely studied. Most of these studies have shown positive relationships between employee engagement levels and individual and organizational outcomes.

Work engagement mediates the relationship between job resources including task variety, autonomy, feedback, task identity and task significance and outcomes such as Organizational Citizenship Behavior (OCB), and task performance\textsuperscript{33}. Hakanen and his
colleagues (2008)\textsuperscript{34} conducted various longitudinal studies which showed that high levels of work engagement lead over time to more organizational commitment, more personal initiative and more innovative behavior at team level. Xanthopoulou and his colleagues (2008)\textsuperscript{35} found in their study that high levels of work engagement lead to less frequent sickness absences in employees. Bakker and Bal, (2010)\textsuperscript{36} found that high levels of work engagement lead to better role performance in employees.

Salanova and his colleagues\textsuperscript{37} in their study concluded that high levels of engagement among students are associated with a higher grade point average (GPA) in term examinations. Mark et al\textsuperscript{38} found that engaged nurses are less often involved in needle accidents than their less engaged colleagues. Hansez and Chmiel (2010)\textsuperscript{39} in their study found that engaged chemical process workers are more committed to safety behaviors than less engaged workers. Sulea and colleagues (2012)\textsuperscript{40} concluded in their study that engaged employees exhibited more organizational citizenship behaviors and less counterproductive work behaviors than their less engaged colleagues. All the above studies have proved that engagement is positively correlated to positive organizational attitudes and behaviors. Salanova Agut and Peiró (2005)\textsuperscript{41} in their study on frontline employees found that the quality of service offered by frontline staff in hotels and restaurants whose levels of engagement were high was rated high by customers. They found high positive association between engagement levels of employees and their service quality. Xanthopoulou\textsuperscript{42} in his study found high positive correlation between engagement levels of employees and financial turnover of the company. All these academic studies have concluded that work engagement leads to positive outcomes for the organization, both at individual level and at team level.

As a part of study by Gallup organization, Harter et al. (2002)\textsuperscript{43} conducted a meta-analysis study that included almost 8,000 business-units of 36 companies. The study revealed that levels of engagement are positively related to indicators of business-unit performance, such as customer satisfaction and loyalty, profitability, productivity, turnover, and safety. More detailed analyses revealed that the top 25 per cent most engaged units had 2 per cent to 4
per cent higher customer satisfaction, 1 per cent to 4 per cent higher profitability, and 13 per cent to 36 per cent lesser turnover compared to less engaged units. Also, the businesses in the top quartile on engagement had, on average $80,000 to $120,000 higher monthly revenues or sales.

In another Gallup study including over 955,000 respondents in the US and 23 other nations, Harter, Schmidt, Killian and Agrawal, (2009) found that work engagement accounted for 78 per cent of the variance in profitability across 17,339 business units. Those business units with higher levels of work engagement had a 94 per cent higher success rate in their own organization and a 145 per cent higher success rate across organizations.

Despite these impressive results, there are some concerns spelled out by scholars that need to be addressed. Some of the studies by organizations lack scientific rigor and transparency. Some studies use a questionnaire that emphasizes on concepts rather than engagement. Hence, the positive outcomes may not be purely associated with engagement and thus requires further study.
Concept of Assertiveness

Assertiveness is defined in Oxford Dictionary as “Forthright, positive, insistence on the recognition of one's rights.” Assertiveness refers to expressing one’s thoughts, feelings and beliefs in direct, honest and appropriate ways. It is an important personal and interpersonal skill. In interactions with other people like employers, customers or colleagues, assertiveness helps individuals to express themselves in a clear, open and reasonable way, without undermining the rights of others. Thus, assertiveness enables individuals to express honest feelings comfortably without undue anxiety and protect their personal rights without denying the rights of others.

Assertiveness is also defined as the process of direct and appropriate communication of a person’s needs, wants and opinions without punishing or putting down others. It can be used as an instrument for initiating and maintaining socially supportive relationships and hence enjoying better emotional well-being. There are many studies that have sought to explore the relationship between assertiveness and mental health. Different studies have found different factors that influence assertiveness. The factors include culture, self-esteem, psychological distress, depression, and gender. Some earlier studies found that boys are more assertive than girls. However, some of the recent studies found that girls are more assertive than boys and some studies proved that there is no significant difference between boys and girls in assertiveness.
Assertive people are able to maintain balanced responses and avoid negative behaviors like passiveness and aggressiveness. Passive and aggressive responses result from a lack of self-confidence. People use such responses when they do not know how to say NO when they are being persuaded by others to do what they do not want to do. They are inappropriate expressions of what people really need to say. Passive responses allow others to lead and make decisions for them. On the other hand, aggressive responses tend to strain relationships with others. Aggressively reacting people fail to consider the feelings, opinions and views of others and thus are disliked in social circles. This hinders their career growth.
Assertiveness involves listening to the views of others and responding appropriately. The response can be agreement with others’ views or non-agreement with others’ views. But the views are expressed clearly and confidently without feeling any fear of being disliked or rejected by the group (Refer Figure 1.5). Assertive people come forward to take responsibility and delegate the tasks to others as required by the situation. When they do any mistake they do not hesitate to apologize. They exercise control over their expressions and words and do not feel inferior to anyone.

Sarkova and his research associates\textsuperscript{46} conducted a study to explore the associations between adolescents’ assertive behavior, psychological well-being, and self-esteem. They collected data from 1,023 students. 47.6\% of the students were boys and 52.4\% of them were girls. The researchers adopted two dimensions of the Scale i.e, distress and performance for measuring interpersonal Behavior, two factors -depression/anxiety and social dysfunction of the General Health Questionnaire-12, and two factors, namely, positive self-esteem and negative self-esteem of the Rosenberg Self-Esteem Scale. Data were analyzed using hierarchical linear regression. The findings of the study were (i) The more anxious respondents felt in assertive situations, the less frequently they engaged in these situations; and that (ii) Assertiveness was associated with psychological well-being and self-esteem.

\textbf{Concept of Job satisfaction}

In simple terms, job satisfaction is how content an individual is with his or her job including various aspects of it like nature of work, peers, supervision, rewards, etc. According to Hirschfeld (2000)\textsuperscript{47}, job satisfaction is the extent to which people like their job. It is a reaction to a job, which stems from the employee's comparison of actual outcomes with the expected outcomes\textsuperscript{48}. If the outcomes exceed their expectations, it leads to job satisfaction. Job satisfaction is influenced by self-efficacy. Self-efficacy is defined by Ballentine & Nunns, (1998)\textsuperscript{49} as the belief in one's own capability to perform a task. Self-efficacy refers to the thoughts and feelings of competence and mastery that are generated through interaction with the environment, which translate into the individual
behaving in a certain way because of expectations of success (Niedinger, 1997). Lapin, (2005) found that in an environment, where employees experience high levels of psychological safety coupled with high levels of accountability, their performance is optimized. Individuals who feel more accountable in the work environment will take more ownership of their output, which leads to an overall increase in productivity. Higher productivity results in higher outcomes and therefore leads to job satisfaction.

According to Terry, Nielsen, & Perchard, (1993), high levels of stress are associated with low levels of job satisfaction. Judge, et al. (1998) found that individuals with an internal locus of control experience higher levels of job satisfaction. This is because individuals with an internal locus of control feel that they are in charge of the situation. They manage any situation by taking right action at right time. Garson & Stanwyck (1997) in their study found that there is a positive correlation between internal locus of control and job satisfaction. Kanfer (1990) found that perceptions of competence could lead to feelings of satisfaction with a task. Thus, the way people evaluate themselves has a definite influence on their job satisfaction.

When an individual experiences job satisfaction, it leads to higher levels of commitment to the profession and organization. This leads to greater success at work. Positive effects of success at work may spill over into an individual's personal life and increase his/her satisfaction in life (Bessokirnaia & Temnitskii, 2002). This will ultimately lead to higher level of psychological well-being of individuals. Job satisfaction is influenced by nature of work, working conditions, level of work related stress, supervision, promotional opportunities, social relationships, workload, pay, feedback, relationship with colleagues, skill variety, skill identity, task significance, supervision, and autonomy. Job satisfaction consists of cognitive and affective behavioral components. Affective job satisfaction is a person's emotional feeling about the job as a whole. It may be a feeling of pleasure or displeasure. Cognitive component refers to perceptions, opinion, beliefs and expectations of employee regarding the organization like pay, hours and benefits. When both affective and cognitive components are positive in an employee he/she is satisfied with the job. A satisfied employee stays longer with the organization. Satisfied employees perform all
those tasks that are required to be performed as a part of their job. They fulfill minimum role expectations like presenting status report every Monday and showing minimum expected progress in their task. They try to maintain good relationships with supervisors, subordinates, and co-workers. Highly satisfied employees may engage in extra role behavior. They will come forward to shoulder additional responsibilities and tasks and invest extra work hours to complete the tasks/projects. They go beyond their job requirements to help customers or clients and help enhance the productivity and profitability of organization. On the other hand, dissatisfied employees look for opportunities outside the organization. Highly dissatisfied employees may engage in destructive behaviors like deleting important data and files.


Job satisfaction mediates relationship between psychological well-being and employee turnover. When job satisfaction is high, the relationship between psychological well-being and employee turnover is low. When job satisfaction is low, the relationship between psychological well-being and employee turnover is high. With job satisfaction being
related to positive constructs and the advantages of having satisfied employees, the question arises as to how to create proud employees, foster commitment and accountability in the workforce. Systematic exposure of an individual to increasingly difficult experiences of substantially difficult tasks, and building on positive qualities could result in career and personal development. Most people can learn to accept, and even seek, responsibility, and to exercise high levels of imagination and creativity in solving organizational demands (Refer Figure 1.6). An individual's increased perception of higher potential, and the manifestation thereof, could lead to increased performance and productivity, and therefore to job satisfaction. In the end, exposure to such demands could lead to job satisfaction and job involvement, as well as organizational commitment - an increased ability and stamina to deal with excessive demands.

**Psychological Well-being and Different Professions**

It is well known that stress levels are high in professions like nursing, police, prison officers, customer service executives, office secretaries, defense officers, R&D personnel, etc. Nurses need to be dedicated, devoted and selfless people ever ready to offer care for the patient like a mother towards her child. According to a study by Sheena Johnson, nurses experience high stress, low psychological well-being and low job satisfaction compared to teachers, accountants, fire safety officers, police, clerks, prison officers, customer service executives and other professionals. The nursing personnel and their psychological well-being cannot be ignored because the recovery of patients suffering from chronic illness, fatal accidents, cardiac arrest, renal failures, etc depends on the quality of service offered by nurses. The first interaction of in-patients in hospitals is with nursing personnel. The image and reputation of hospitals depends on the commitment with which nurses offer services to patients.
SIGNIFICANCE OF NURSING PERSONNEL AND HOSPITALS

According to the World Bank, development indicators of a developed economy not only include GDP, education and environment but also Health of people. The health status of people plays an equally important role in determining the development status of a country. The World Health Organization (WHO) released its 2015 report revealing the statistics about the health systems of various economies. The important parameters considered for this purpose are Health expenditure, Number of nurses, doctors and health workers per 1000 people, Number of hospital beds per 1000 people and completeness of birth registration (Refer Table 1.1).

Table 1.1

State/UT-wise number of Government Hospitals in Rural and Urban areas in India

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Name of the State/UT</th>
<th>Total Number of Hospitals available</th>
<th>Beds available</th>
<th>Average population served per Government Hospital bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Andhra Pradesh</td>
<td>460</td>
<td>37961</td>
<td>2230</td>
</tr>
<tr>
<td>2</td>
<td>Arunachal Pradesh</td>
<td>384</td>
<td>5010</td>
<td>236</td>
</tr>
<tr>
<td>3</td>
<td>Assam</td>
<td>1020</td>
<td>10179</td>
<td>3062</td>
</tr>
<tr>
<td>4</td>
<td>Bihar</td>
<td>671</td>
<td>13231</td>
<td>7846</td>
</tr>
<tr>
<td>5</td>
<td>Chhattisgarh</td>
<td>2023</td>
<td>10770</td>
<td>1984</td>
</tr>
<tr>
<td>6</td>
<td>Goa</td>
<td>11</td>
<td>2510</td>
<td>581</td>
</tr>
<tr>
<td>7</td>
<td>Gujarat</td>
<td>1553</td>
<td>35470</td>
<td>1746</td>
</tr>
<tr>
<td>8</td>
<td>Haryana</td>
<td>154</td>
<td>7879</td>
<td>3122</td>
</tr>
<tr>
<td>9</td>
<td>Himachal Pradesh</td>
<td>151</td>
<td>8485</td>
<td>808</td>
</tr>
<tr>
<td>10</td>
<td>Jammu &amp; Kashmir</td>
<td>1969</td>
<td>7318</td>
<td>1733</td>
</tr>
<tr>
<td>11</td>
<td>Jharkhand</td>
<td>549</td>
<td>5414</td>
<td>6089</td>
</tr>
<tr>
<td></td>
<td>State</td>
<td>Confirmed</td>
<td>Active</td>
<td>Deaths</td>
</tr>
<tr>
<td>---</td>
<td>------------------------</td>
<td>-----------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>12</td>
<td>Karnataka</td>
<td>765</td>
<td>51986</td>
<td>1119</td>
</tr>
<tr>
<td>13</td>
<td>Kerala</td>
<td>1255</td>
<td>37021</td>
<td>910</td>
</tr>
<tr>
<td>14</td>
<td>Madhya Pradesh</td>
<td>1539</td>
<td>30302</td>
<td>2492</td>
</tr>
<tr>
<td>15</td>
<td>Maharashtra</td>
<td>1173</td>
<td>47217</td>
<td>2477</td>
</tr>
<tr>
<td>16</td>
<td>Manipur</td>
<td>225</td>
<td>1385</td>
<td>2</td>
</tr>
<tr>
<td>17</td>
<td>Meghalaya</td>
<td>40</td>
<td>2957</td>
<td>876</td>
</tr>
<tr>
<td>18</td>
<td>Mizoram</td>
<td>22</td>
<td>1064</td>
<td>1132</td>
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<tr>
<td>19</td>
<td>Nagaland</td>
<td>53</td>
<td>2427</td>
<td>905</td>
</tr>
<tr>
<td>20</td>
<td>Orissa</td>
<td>1750</td>
<td>16683</td>
<td>2514</td>
</tr>
<tr>
<td>21</td>
<td>Punjab</td>
<td>243</td>
<td>11419</td>
<td>2426</td>
</tr>
<tr>
<td>22</td>
<td>Rajasthan</td>
<td>2512</td>
<td>38617</td>
<td>1777</td>
</tr>
<tr>
<td>23</td>
<td>Sikkim</td>
<td>33</td>
<td>1560</td>
<td>390</td>
</tr>
<tr>
<td>24</td>
<td>Tamil Nadu</td>
<td>1995</td>
<td>62229</td>
<td>1203</td>
</tr>
<tr>
<td>25</td>
<td>Tripura</td>
<td>39</td>
<td>3485</td>
<td>1026</td>
</tr>
<tr>
<td>26</td>
<td>Uttar Pradesh</td>
<td>861</td>
<td>56384</td>
<td>3499</td>
</tr>
<tr>
<td>27</td>
<td>Uttarakhand</td>
<td>695</td>
<td>7965</td>
<td>1194</td>
</tr>
<tr>
<td>28</td>
<td>West Bengal</td>
<td>1566</td>
<td>77210</td>
<td>1213</td>
</tr>
<tr>
<td>29</td>
<td>Andaman &amp; Nicobar Islands</td>
<td>32</td>
<td>1075</td>
<td>353</td>
</tr>
<tr>
<td>30</td>
<td>Chandigarh</td>
<td>5</td>
<td>1750</td>
<td>603</td>
</tr>
<tr>
<td>31</td>
<td>Dadra &amp; Nagar Haveli</td>
<td>2</td>
<td>281</td>
<td>1221</td>
</tr>
<tr>
<td>32</td>
<td>Daman &amp; Diu</td>
<td>4</td>
<td>200</td>
<td>1215</td>
</tr>
<tr>
<td>33</td>
<td>Delhi</td>
<td>109</td>
<td>22961</td>
<td>744</td>
</tr>
<tr>
<td>34</td>
<td>Lakshadweep</td>
<td>3</td>
<td>120</td>
<td>533</td>
</tr>
<tr>
<td>35</td>
<td>Puducherry</td>
<td>50</td>
<td>2103</td>
<td>571</td>
</tr>
<tr>
<td></td>
<td>India</td>
<td>35416</td>
<td>1376013</td>
<td>879</td>
</tr>
</tbody>
</table>

*Source: Ministry of Health and Family Welfare, August 14, 2013*
Health expenditure, total (% of GDP): Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

Health expenditure, public (% of total health expenditure): Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds. Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

Out-of-pocket health expenditure (% of total expenditure on health): Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.

External resources for health (% of total expenditure on health): External resources for health are funds or services in kind that are provided by entities not part of the country in question. The resources may come from international organizations, other countries through bilateral arrangements, or foreign nongovernmental organizations. These resources are part of total health expenditure.

Health expenditure per capita (current US$): Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in current U.S. dollars.
Health expenditure per capita, PPP (constant 2011 international $): Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in international dollars converted using 2011 purchasing power parity (PPP) rates.

Physicians (per 1,000 people): Physicians include general and specialist medical practitioners.

Nurses and midwives (per 1,000 people): Nurses and midwives include professional nurses, professional midwives, auxiliary nurses, auxiliary midwives, enrolled nurses, enrolled midwives and other associated personnel, such as dental nurses and primary care nurses (Refer Table 1.2).

Table 1.2

Number of Nurses Per 10,000 Population in Some Regions

The numbers in ( ) show percent changes from 2009, and actual N per population in the 2009 report.

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of Nurses</th>
<th>N per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>805,000 (+1.6%)</td>
<td>11 (11)</td>
</tr>
<tr>
<td>Americas</td>
<td>5,259,000 (+28.4%)</td>
<td>61 (49)</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>2,224,000 (+13.7%)</td>
<td>13 (12)</td>
</tr>
<tr>
<td>Europe</td>
<td>6,620,000 (-0.6%)</td>
<td>75 (79)</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>870,000 (+18.4%)</td>
<td>15 (15)</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>3,600,000 (+5.4%)</td>
<td>20 (20)</td>
</tr>
<tr>
<td>Total</td>
<td>19,380,000 (+9.8%)</td>
<td>30 (28)</td>
</tr>
</tbody>
</table>

Source: Health Organization’s World Health Statistics Report, 2011
Table 1.3
Nurses in English Speaking Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of Nurses</th>
<th>N per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>201,000 (+6.9%)</td>
<td>96 (97)</td>
</tr>
<tr>
<td>Canada</td>
<td>350,000 (-1.8%)</td>
<td>101 (101)</td>
</tr>
<tr>
<td>India</td>
<td>1,431,000 (+4.3%)</td>
<td>13 (13)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>44,000 (+33.3%)</td>
<td>108 (89)</td>
</tr>
<tr>
<td>Philippines</td>
<td>488,000 (+1.4%)</td>
<td>60 (61)</td>
</tr>
<tr>
<td>South Africa</td>
<td>184,000 (0%)</td>
<td>41 (41)</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>621,000 (-16.1%)</td>
<td>103 (128)</td>
</tr>
<tr>
<td>United States of America</td>
<td>2,927,000 (+9.6%)</td>
<td>98 (94)</td>
</tr>
<tr>
<td>Total</td>
<td>6,223,000 (+13.7%)</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Health Organization's World Health Statistics Report, 2011*

Nursing Personnel

There are 19.3 million nurses and midwives according to the World Health Organization's World Health Statistics Report, 2011. According to the Planning Commission’s National Task Force Report 2012, more than 14 lakh registered nurses work in India today (*Refer Table 1.3*). Of these, more than 70 per cent are women. According to a study titled *Human Resources for Health in India*, published in *The Lancet* in January 2011, nurses and midwives constitute 30 per cent of the country’s total healthcare workforce. Of these, many go through stressful times at work, for reasons ranging from poor pay, long work hours, work pressure and absence of social security to administrative apathy. Many leave the
profession midway. Delhi is considered to be one of the few places in the country where nurses enjoy better pay and a relatively better work culture. In other cities and small towns, hospitals pay only meager wages to healthcare staff, including nurses. a stretch, without any over-time benefits. This is because of the long-pending recruitment of nurses in Government hospitals.

Nurses have many responsibilities at work. Apart from assisting patients and doctors, they have to deal with the anger of patients, their families, even doctors, hospital management and visitors. Unlike many other services, nursing demands from the worker a great range of skills and people management expertise. But nurses in India rarely have the avenue to upgrade their skills.

In Australia, a country to which many nurses from India migrate, nurses get sufficient on-job training to deal with most problems. More importantly, they have to renew their registration every year, which leads to an audit of their skills and work practices. The Government regulations there insist that each nurse should dedicate certain hours of her work for education.

From time to time, nurses are given training to deal with work stress, demanding families, and other life difficulties. Many hospitals in Australia, have a ‘nurse educator’, who runs short and useful courses for nursing staff on myriad subjects.

Nurses are also encouraged to do various mid to long-term courses offered by the neighborhood chain of hospitals, at the hospital’s cost. The government offers up to $1,500-2,000 a year as an allowance to nurses who can use the money to attend career enhancing programmes or, at least, buy books. Nurses also get 40 hours of paid leave for professional development.

In Australia, the US and other developed countries, nursing profession draws respect. In India, nurses are often bullied and harassed, apart from being paid meager salaries. Many
nurses hesitate to even talk about their profession. Many private hospitals in Indian cities pay a fresh recruit anything between Rs. 2,000-8,000 a month and those with five years or more experience a maximum of Rs. 15,000 a month.

In Australia, while a doctor entering the profession is paid $30-32 an hour, a nurse too gets about $28-30. In India, while an MBBS graduate is paid about Rs. 45,000 at the start of her career in private hospitals, a nursing graduate gets a maximum of Rs. 8,000. While doctors enjoy several other perks, nurses are often left with minimum facilities and zero benefits.

One of the reasons why nurses in the UK or Australia enjoy a better life is the presence of strong and effective nursing unions. In these countries, nurses’ unions command immense clout. Australian Nursing and Midwifery Federation, said to be the largest in the country, represents registered nurses, enrolled nurses, midwives and nursing assistants in every state and territory throughout Australia. It has 230,000 dedicated members.

In India, though some associations like Trained Nurses Association of India have been in existence for decades, they have not been very effective in integrating members and strengthening the voice of nurses. This lack of bargaining power of unions helps managements to easily calm down demands for better pay and work atmosphere. Such a situation is one of the many reasons why most nurses want to immigrate to other countries. For instance, the Lancet study shows the number of new Indian nurse registrants in the UK grew from 30 in 1998 to 3,551 in 2005. Indians constitute the second largest group of visa seekers as nurses in the US.

But of late, India’s nurses have gained hitherto-unseen collective power. For instance, prompted by various incidences of oppression, nurses in Kerala in 2011 formed a collective, Indian Nurses Association, to act as an umbrella organization of all nursing unions in the country. Nurses in cities such as Delhi, Kochi and Chennai staged several strikes in the recent past to communicate to public and the government about their miseries.
According to Siju Thomas, general secretary of Delhi Private Nurses Association, a change in government policy is required at this juncture. There should be a system that ensures minimum wages for nurses and the hospitals should be held responsible and penalised if they have alarmingly poor nurse-to-patient ratios.

HOSPITALS

A hospital is an institution, which provides curative, restorative and preventive health services to patients through well qualified and experienced personnel. Hospitals provide patient treatment with specialized staff and equipment. Hospitals also conduct educational and training programmes for the health personnel particularly required for patient care and hospital services. Some hospitals also conduct research in assisting the advancement of medical services and hospital services and conduct programmes of health education. Thus, hospitals not only provide medical care to community, but also act as centers for education and research for all types of health professionals. In order to meet all these needs, the hospital works through many departments like

- Emergency department
- Coronary Care Unit
- Intensive care unit
- Paediatric intensive care unit
- Neonatal intensive care unit
- Neurology
- Oncology
- Obstetrics and Gynaecology
- Long-term care (LTC)

**Emergency department:** An emergency department (ED), or casualty department, is a medical treatment facility specializing in emergency medicine, that is, acute care of patients who present themselves without prior appointment, either by their own means or by ambulance.
Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. The emergency departments of most hospitals operate 24 hours a day, although staffing levels may be varied from time to time depending on patient volume.

A typical hospital has its emergency department in the ground floor, with its own dedicated entrance. As patients can be present at any time and with any complaint, a key part of the operation of an emergency department is the prioritization of cases based on clinical need. This process is called triage.

**Exhibit 1.1**

**Emergency Department**

*Image: Integrated Emergency Response System at Max Hospitals*
Triage is normally the first stage the patient passes through, and consists of a brief assessment, including a set of vital signs, and the assignment of a "chief complaint" (e.g. chest pain, abdominal pain, difficulty in breathing, etc.). Most emergency departments have a dedicated area for this process to take place, and may have staff dedicated to a triage role. In most departments, this role is performed by a nurse. In some countries, trained health care professionals may perform the triage sorting, including paramedics or physicians. Triage is typically conducted face-to-face when the patient presents, or a form of triage may be conducted via radio with an ambulance crew; in this method, the paramedics will call the hospital's triage center with a short update about an incoming patient, who will then be triaged to the appropriate level of care.

Most patients will be initially assessed at triage and then passed to another area of the department, or another area of the hospital, with their waiting time determined by their clinical need. However, some patients may complete their treatment at the triage stage, for instance, if the condition is very minor and can be treated quickly, if only advice is required, or if the emergency department is not a suitable point of care for the patient. Conversely, patients with evidently serious conditions, such as cardiac arrest, will bypass triage altogether and move straight to the appropriate part of the department.

The resuscitation area, commonly referred to as "Trauma" or "Resus", is a key area in most departments. The most seriously ill or injured patients will be dealt with in this area, as it contains the equipment and staff required for dealing with immediately life-threatening illnesses and injuries. Typical resuscitation staffing involves at least one attending physician, and at least one and usually two nurses with trauma and Advanced Cardiac Life Support training.
Patients who exhibit signs of being seriously ill but are not in immediate danger of life or limb will be triaged to "acute care" or "majors," where they will be seen by a physician and receive a more thorough assessment and treatment. For example, patients suffering from chest pain, difficulty in breathing, abdominal pain and neurological complaints are shifted to acute care department. Advanced diagnostic testing may be conducted at this stage, including laboratory testing of blood and/or urine, ultrasonography, CT or MRI scanning. Medications appropriate to manage the patient's condition will also be given. Depending on underlying causes of the patient's chief complaint, he or she may be discharged from this area or admitted to the hospital for further treatment.

**Coronary Care Unit (CCU):** A coronary care unit (CCU) or cardiac intensive care unit (CICU) is a hospital ward specialized in the care of patients with heart attacks and other cardiac conditions that require continuous monitoring and treatment. The main feature of coronary care is the availability of telemetry or the continuous monitoring of the cardiac rhythm by electrocardiography (the recording of the activity of the heart using an electric device). This allows early intervention with medication (giving right dose of right medicine), cardioversion (a medical procedure by which an abnormal heart rate is converted to a normal rhythm using electricity or drugs) or defibrillation (delivering a therapeutic dose of electrical energy to the heart with a device called a defibrillator), improving the prognosis. As arrhythmias (irregular heartbeat) are relatively common in this group, patients with myocardial infarction or unstable angina are routinely admitted to the coronary care unit. For other indications, such as atrial fibrillation (abnormal heart rhythm), a specific indication is generally necessary, while for others, such as heart block, coronary care unit admission is standard.

CCU is attended by doctors specializing in cardiology. Cardiology (cardio-"heart" and -logia, "study") is a branch of medicine dealing with disorders of the heart. The field includes medical diagnosis and treatment of congenital heart defects, coronary artery disease, heart failure, valvular heart disease and electrophysiology. Physicians who specialize in this field of medicine are called cardiologists, a specialty of internal medicine.
Pediatric cardiologists are pediatricians who specialize in cardiology. Physicians who specialize in cardiac surgery are called cardiothoracic surgeons or cardiac surgeons, a specialty of general surgery.

**Exhibit 1.2**
**Coronary Care Unit**

![Cardiac surgery on patient](image)

**Image:** Cardiac surgery on patient

**Adult cardiology**
Cardiology is a specialty of internal medicine. It is the study of the disorders of the heart. The doctors who are trained to take care of heart ailments are cardiologists. The cardiologists who are adequately trained to take care of adults are called adult cardiologists.

**Pediatric cardiology**
The study of child heart disorders is called Pediatric cardiology. The cardiologists who are trained adequately to take care of ailments of heart in children are called pediatric cardiologists.

**Intensive care unit (ICU):** It is also known as an intensive therapy unit or intensive treatment unit (ITU) or critical care unit (CCU), is a special department of a hospital or health care facility that provides intensive care medicine.
Intensive care units cater to patients with the most severe and life-threatening illnesses and injuries, which require constant, close monitoring and support from specialist equipment and medications in order to ensure normal bodily functions. They are staffed by highly trained doctors and critical care nurses who specialize in caring for seriously ill patients. Common conditions that are treated within ICUs include trauma, multiple organ failure and sepsis.

**Exhibit 1.3**

**ICU**

*Image: Doctor and Nurse attending a patient in ICU*

Patients may be transferred directly to an ICU from an emergency department if required, or from a ward if they rapidly deteriorate, or immediately after surgery if the surgery is very invasive and the patient is at high risk of complications.

**A Pediatric Intensive Care Unit (PICU):** It is a department specializing in the care of critically ill infants, children, and teenagers. A PICU is typically directed by one or more PICU specialists and staffed by doctors, nurses, and respiratory therapists who are specially trained and experienced in pediatric intensive care. The unit may also have physician assistants, physiotherapists, etc. The ratio of professionals to patients is generally higher than in other areas of the hospital, reflecting the acuity of PICU patients and the risk of life-threatening complications. Complex technology and equipment is often in use,
particularly mechanical ventilators and patient monitoring systems. Consequently, PICUs have a larger operating budget than many other departments within the hospital.

**Neonatal Intensive-Care Unit (NICU):** It is also known as an intensive care nursery (ICN), is an intensive-care unit specializing in the care of ill or premature newborn infants. A NICU is typically directed by one or more neonatologists and staffed by nurses, nurse practitioners, pharmacists, physician assistants, resident physicians, and respiratory therapists. Many other ancillary disciplines and specialists are available at larger units.

**Exhibit 1.4**

NICU

![Image: A newborn infant in NICU](image)

A nurse practitioner (NP) is a professional patient caretaker. She/he is an Advanced Practice Registered Nurse (APRN) who has completed advanced coursework and clinical education and therefore qualified to diagnose medical problems, order treatments, perform advanced procedures, prescribe medications, and make referrals for a wide range of acute and chronic medical conditions within their scope of practice.

**Neurology** is a branch of medicine dealing with disorders of the nervous system. Neurology deals with the diagnosis and treatment of all categories of conditions and diseases involving the central and peripheral nervous system (and its subdivisions, the autonomic nervous system and the somatic nervous system); including their coverings,
blood vessels, and all effector tissue, such as muscle. Neurological practice relies heavily on the field of neuroscience, which is the scientific study of the nervous system.

Exhibit 1.5

Neurology

Image: An epilepsy patient being treated

Neurology includes more than 100 subspecialized experts trained in epilepsy (a central nervous system disorder causing seizures), movement disorders (abnormal and involuntary movements), dementias and other cognitive conditions (brain conditions that affect memory and thinking skills), stroke and cerebrovascular diseases (brain and blood vessel problems), neuro-oncology, multiple sclerosis (the protective shield around nervous system is attacked by immune system disrupting the communication between brain and body), demyelinating disorders (spinal cord and optical nerves damaged causing loss of vision, sensation, bladder function, etc), autoimmune neurology, pediatric neurology, neurophysiology, headache, neuromuscular diseases, peripheral nerve, sleep neurology, and speech pathology. These care providers work together to evaluate and treat people utilizing the most advanced techniques ad technologies.

Oncology: It deals with comprehensive cancer diagnosis and treatment programs. Depending upon the cancer identified, followup and palliative care will be administered at that time. Certain disorders (such as Acute Lymphoblastic Leukemia – ALL, where overproduction of white blood cells damages and kills normal cells) will require immediate admission and chemotherapy, while others will be followed up with regular physical examination and blood tests.
Often, surgery is attempted to remove a tumor entirely. This is only feasible when there is some degree of certainty that the tumor can in fact be removed. When it is certain that parts will remain, curative surgery is often impossible, e.g. when there are metastases (the spread of cancer from one part to other unrelated parts) elsewhere, or when the tumor has invaded a structure that cannot be operated upon without risking the patient's life. Occasionally surgery can improve survival even if not all tumour tissue has been removed; the procedure is referred to as "debulking" (i.e. reducing the overall amount of tumour tissue). Surgery is also used for the palliative treatment of some of cancers, e.g. to relieve biliary obstruction, or to relieve the problems associated with some cerebral tumors. The risks of surgery must be weighed against the benefits. Palliative care focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness—whatever the diagnosis. The goal of such therapy is to improve quality of life for both the patient and the family. Palliative care is provided by a team of physicians, nurses, and other health professionals who work together with the primary care physician and referred specialists (or, for patients who don't have those, hospital or hospice staff) to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Chemotherapy and radiotherapy are used as a first-line radical therapy in a number of malignancies. They are also used for adjuvant therapy, i.e. when the macroscopic tumor has already been completely removed surgically but there is a reasonable statistical risk that it will recur. Chemotherapy and radiotherapy are commonly used for palliation, where disease is clearly incurable: in this situation the aim is to improve the quality of life and to prolong it.

Hormone manipulation is well established, particularly in the treatment of breast and prostate cancer. There is currently a rapid expansion in the use of monoclonal antibody treatments and cervical cancer vaccine. Immunotherapies are the subject of intensive research.
Exhibit 1.6
Oncology

Image on left: A woman being treated with chemotherapy for breast cancer. Cold mittens and wine coolers are placed on her hands and feet to reduce harm to her nails. Image on right: radiotherapy on hand

An oncology nurse is a specialized nurse who cares for cancer patients. Currently there currently exists only one educational program in oncology nursing that is being offered by the European Institute of Health Sciences. It has been approved by the Ministry of Higher Education as well as the Ministry of Health in 2014. The duration of this Bachelor of Science program in Oncology Nursing is 3 years and encompasses a total of 6 thousands hours, equivalent to 120 semester credits in the US educational system and 180 ECTS in the European system. The program attracts a large number of students from African countries.

6. Obstetrics and Gynaecology: Obstetrics deals with pregnancy, childbirth, and postpartum period (including care of the newborn). The obstetrician cares in prenatal stage of women by screening for any complications in pregnancy, suggesting necessary diet and exercises, medicines, etc to be taken to ensure safe delivery.
The nurse assists obstetrician in monitoring the progress of labor, by reviewing the nursing chart, performing vaginal examination, and assessing the trace produced by a fetal monitoring device (the cardiotocograph), accelerate the progress of labor by infusion of the hormone oxytocin, provide pain relief, either by nitrous oxide, opiates, or by epidural anesthesia done by anesthetists, an anesthesiologist, or a nurse anesthetist, surgically assisting labor, by forceps or the ventouse (a suction cap applied to the fetus' head) or Caesarean section.

Nurses care for women in labour and through the delivery. The nurse constantly assesses the woman and the fetus, and the progress of labour. As a minimum, in the first stage of labour, the midwife listens to the fetal heart for one minute every fifteen minutes, measure the woman's pulse hourly and record her blood pressure and temperature four hourly. She encourages the woman to empty her bladder every four hours, and measures and analyses each void. She offers an abdominal palpation and vaginal examination every four hours. In the second stage of labour, the fetal heart is auscultated for one minute every five minutes, the pulse and blood pressure measured hourly, temperature every four hours, abdominal palpation and vaginal examination hourly, and the woman is encouraged to void frequently. These are all minimums. If the woman was on continuous fetal monitoring, the nurse would formally review this hourly. The nurse would refer to another health care practitioner if the labour deviated from the norm or if the woman requested an epidural. The nurse should discuss the woman's birth plan with her and explain the options regarding labour to the woman.

The nurse also assists in a postnatal assessment including the woman's observations, general well-being, lactation status, caesarean wounds, stitches, bowel problems etc. The baby is also checked for weight, respiratory effort, tone, heart rate, response to stimuli, jaundice, signs of adequate feeding, or other concerns. The baby has a nursery exam between six and seventy two hours of birth to check for conditions such as heart defects, hip problems, or eye problems.
**Gynaecology** is the medical practice dealing with the health of the female reproductive systems (vagina, uterus and ovaries) and the breasts. Literally, outside medicine, it means "the science of women".

The main conditions dealt with by a gynaecologist are: Cancer and pre-cancerous diseases of the reproductive organs including ovaries, fallopian tubes, uterus, cervix, vagina, and vulva, Incontinence of urine, Amenorrhoea (absence of menstrual periods), Dysmenorrhoea (painful menstrual periods), Infertility, Menorrhagia (heavy menstrual periods); a common indication for hysterectomy, Prolapse of pelvic organs, Infections of the vagina (vaginitis), cervix and uterus (including fungal, bacterial, viral, and protozoal), There is some crossover in these areas with other specialists. For example, a woman with urinary incontinence may be referred by gynaecologist to a urologist.

**Exhibit 1.7**
**Obstetrics**

**Image**: Inauguration of IVF facility at Obstetrics and Gynaecology department of AIIMS

**Long-term care (LTC)**: It includes variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time. The long term care is generally given to elderly patients, patients recovering from orthopedic procedures or fractures, patients recovering from stroke, patients with Advanced Cancer and patients with dementia, paralysis, or psychological problems, etc.
It is common for long-term care to provide custodial and non-skilled care, such as assisting with normal daily tasks like dressing, and using the bathroom. Increasingly, long-term care involves providing a level of medical care that requires the expertise of skilled practitioners to address the often multiple chronic conditions associated with older populations. Long-term care can be provided at home, in the community, in assisted living facilities or in nursing homes. Long-term care may be needed. Long-term care can be provided formally or informally. Facilities that offer formal LTC services typically provide living accommodation for people who require on-site delivery of around-the-clock supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping. These facilities may go under various names, such as nursing home, personal care facility, residential continuing care facility, etc.

Exhibit 1.8

Long Term Care

Image: Long Term Care being provided to old aged patients

LTC is provided formally in the home, also known as home health care. It can incorporate a wide range of clinical services like nursing, drug therapy and physical and other activities such as physical construction like installing hydraulic lifts, renovating bathrooms and kitchens. These services are usually ordered by a physician or other professional. Depending on the country and nature of the health and social care system, some of the costs of these services may be covered by health insurance or long-term care insurance.
In addition, there is the Department of Nursing, often headed by a Chief Nursing Officer or Director of Nursing. This department is responsible for administration of professional nursing practice, research, and policy for the hospital. Nursing permeates every part of a hospital. Many units or wards have both a nursing and a medical director that serve as administrators for their respective disciplines within that specialty. For example, in an intensive care nursery the Director of Neonatology will be responsible for the medical staff and medical care while the Nursing Manager/Director for the intensive care nursery, will be responsible for all of the nurses and nursing care on that unit/ward.

Some hospitals will have outpatient departments and some will have chronic treatment units such as behavioral health services, dentistry, dermatology, psychiatric ward, rehabilitation services, and physical therapy.

Common support units include a dispensary or pharmacy, pathology, and radiology, and on the non-medical side, there often are medical records departments, release of information departments, Information Management (IM, IT or IS), Clinical Engineering (Biomed), Facilities Management, Plant Ops (Maintenance), Dining Services, and Security departments.

Hospitals have different departments which deal with different kinds of services e.g. medical, nursing, pharmacy, laboratory services etc. Among all these services the nursing service is that part of the hospital which aims to satisfy the nursing needs of the patient and community. The nursing service is closest to the patients 24 hours of the day and seven days of the week.

In most hospitals, the Director is the overall incharge of the Institute, and the Medical Superintendent is overall incharge of the Hospital under whose supervision the Nursing Department works. The Chief Nursing Officer heads the Nursing Department in Autonomous hospital and in the government and private hospitals, nursing department is headed by Nursing Superintendent. She is responsible for administration and management of the Nursing Department. She is directly responsible to the Medical Superintendent and through the Medical Superintendent to the Director. In Autonomous hospitals the post of Nursing Superintendent is next to the Chief Nursing Officer and she is responsible to the
Chief Nursing Officer in the hospital for administration and management of nursing services (Refer Figure 1.7).

List of Some Autonomous Hospitals in India

- NIMS Hyderabad, Telangana
- Kidwai Memorial Institute of Oncology Banglore, Karnataka
- AIIMS, Delhi
- Postgraduate Institute of Medical Education and Research (or PGIMER), Chandigarh
- SVIMS, Tirupati, AP
- National Institute Of Homoeopathy, Kolkata
- AIIMS, Bhopal, Madhya Pradesh
- AIIMS Bhubaneswar, Odisha
- AIIMS, Jodhpur, Rajasthan
- AIIMS, Patna, Bihar
- AIMS, Raipur, Chattisgarh
- AIIMS, Rishikesh, Uttarakhand

Classification of Hospitals

Hospitals can be classified on the basis of ownership/control, clinical basis, length of stay of patients and teaching or non-teaching status. As per ownership basis the hospitals can be classified into public, private and autonomous hospitals. The public hospitals can be further classified as Central Government Hospitals and State Government Hospitals. In the present study we have covered three hospitals, which differ as per their ownership i.e. an autonomous, a private and a State Government hospital (List of Private Hospitals in India recognised under CS(MA) Rules, 1944 is given in Appendix).

Autonomy in administration means the freedom in deciding all the matters involved in the day-to-day functioning of the hospital and the discharge of the functions defined by the mission statement.
Autonomy in Medical Care was meant to provide efficient services to patients at autonomous hospitals. Irrespective of the classification of hospitals, the primary function of a hospital is the provision of medical care to a community, to be a centre for education and research for all types of health professionals. In order to meet all these needs, the hospital
works through many departments, which deal with different kinds of services e.g. medical, nursing, pharmacy, diagnostic laboratory services etc. Among all these services, the nursing service is that part of the hospital which aims to satisfy the nursing needs of the patient and community. The nursing service is closest to the patients 24 hours of the day and seven days a week. Nurses constitute the largest proportion of the hospital staff. Planning, organizing, directing and coordinating the individualized care of hospitalized patient is the most important function of a hospital nursing service. All other nursing functions and activities are related to it. A hospital may be well organized, aesthetically decorated and well equipped but if nursing care is not up to the expectations of patients, the hospital will fail in its responsibility. Therefore, the present study focuses on nurses in three selected hospitals in each of the two cities - Hyderabad and Delhi: Gandhi Medical College, NIMs and Kamineni hospitals in Hyderabad and Lok Nayak Jai Prakash Narayana Hospital, AIIMs and Matrix hospitals in Delhi.

Plan of the Study

The entire study is divided into five chapters. First Chapter provides the overview of concept of psychological well-being and its determinants. It also includes the significance of nursing profession, problems and challenges faced by nurses. It also describes various departments in hospitals, their functioning and the role of nurses in them. Second Chapter specifies the need, scope and objectives of the present study. Also, it discusses the research methodology adopted in the present study for determining sample size and data collection and data analysis techniques used to interpret the valuable insights from the data. It then describes literature review and identifies the research gap for the present study. Third Chapter describes the profiles of hospitals from where responses were obtained from nurses to the Questionnaire used in the study. Fourth Chapter presents the detailed Data analysis and interpretation. Chapter Five discusses the major findings of the study, Limitations of the study, conclusion based on findings and proposes the recommendations to enhance psychological well-being of nursing personnel.
REFERENCES


